MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE _____/_____/_____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATION : See Notes

VACCINE TYPE						VACCINE TYPE				
DOSE #	DTP-DTaP MO/DAY/YR	DT-Td MO/DAY/YR	Polio MO/DAY/YR	Hib MO/DAY/YR	Hep B MO/DAY/YR	DOSE #	M-M-R MO/DAY/YR	MEASLES MO/DAY/YR	RUBELLA MO/DAY/YR	MUMPS MO/DAY/YR
1						1				
2						2				
3						DOSE #	Varicella MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER VAX MO/DAY/YR	OTHER VAX MO/DAY/YR
4						1				
5						2				

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. _____
Signature Title Date

2. _____
Signature or Initial Title Date

3. _____
Signature or Initial Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

LOST OR DESTROYED RECORDS: (Must Be Reviewed and Approved by Local Health Department. See Notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed _____ Date _____
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:
The physical condition of the above pupil is such that immunization at this time would constitute a serious threat to his/her health.
This is a permanent condition ☐ temporary condition ☐ until _____/_____/_____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed _____ Date _____
Physician or Health Official

RELIGIOUS OBJECTION:
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunization being given to my child.
Signed _____ Date _____